# Provider Alternative Action Form

Fax completed form to: 866-345-1193

## PURPOSE OF FORM:

Are you unable to complete the reasonable alternative listed in Section 3, but want another way to earn your incentive reward? Please complete this form with your health care provider by 12/31/2016 and fax it to the number above by 01/15/2017. The alternative activity(s) your provider recommends will be documented, and your reward will be processed in 7-14 days. Note: you will need to complete a new form with your provider's signature, each incentive year to qualify.

## ENTIRE FORM MUST BE COMPLETED:

**Participant:** Complete Section 1 and 2 **Provider:** Complete Section 3 and 4 **Fax:** Completed form to number listed above

PARTICIPANT TO COMPLETE:

| Section 1: Participant Information (please print — all fields required) | | | |
|---|---|---|---|
| Print Legal First | Last Name | | Delta Air Lines, 0226310 |
| Street Address, Apt #, PO Box | | | |
| City | | State | Zip Code |
| Home Phone (with area code)<br>( ) | Day or Cell Phone (with area code)<br>( ) | | Email Address |
| Employee ID | | | Date of Birth (mm / dd / yyyy) |

| Section 2: Participant's Signature — Required For All Requests | |
|---|---|
| By signing this form, I verify that the information supplied by myself or my representative is true and complete. I agree to follow my health provider's alternative action (as recommended below) to earn my incentive reward. I also understand that any person who knowingly intends to injure, defraud or deceive any insurer files by providing false, incomplete or misleading information may be subject to penalties under applicable laws. | |
| Participant's Signature | Date (mm / dd / yyyy) |

PROVIDER / PHYSICIAN TO COMPLETE:

| Section 3: Provider / Physician Alternative Action And Sign Section 4<br>For the wellness activity(s) listed below, it would be unreasonably difficult or medically inadvisable for my patient to complete the alternative program. In lieu of completing the wellness program listed here, I have advised my patient to follow an alternative action to meet this requirement. I have provided my recommendation next to each activity, so my patient may earn an incentive reward. | |
|---|---|
| Telephonic Wellness Coaching or 3 Rally Missions Alternative:<br>As an alternative to meeting outcomes based biometric targets, the participant has the opportunity to earn their incentive reward by completing a Telephonic Wellness Coaching program or 3 Rally Missions. | Provider Recommended Alternative Action:<br>In lieu of the alternatives listed, I recommend: |
| Quit Tobacco Alternative:<br>As an alternative to meeting a tobacco/nicotine free target, the participant has the opportunity to earn their incentive reward by completing Quit Tobacco (call 877-912-1820).<br>. | Provider Recommended Alternative Action:<br>In lieu of the Quit Tobacco, I recommend: |

| Section 4: Provider / Physician's Signature — Required for Processing<br>Provider / physician's signature, or stamp, must be completed before form can be processed. | |
|---|---|
| Provider's Name (print please) | Provider's Office / Clinic Name |
| Provider's Phone Number (with area code)<br>( ) | Provider's NPI Number |
| Provider's Signature | Date (mm / dd / yyyy) |

*Optum is the administrator of the Provider Alternative Action Form / Reasonable Alternative Process (litcode: 9_2013)*